SUPPORTIVE HOUSING INITIATIVE

TRAINING MANUAL FOR PROJECT EVALUATORS

TABLE OF CONTENTS

APPENDICES

Chapter 1
Introduction

Background

The number of people without permanent housing increased substantially in the last two decades of the twentieth century (Morse, 1992; Rossi, 1990). Factors contributing to this increase include deinstitutionalization of the mentally ill, the recessions of the 1980s, changes in the labor market, reductions in welfare and educational programs, and a decline in the availability of low cost housing (Greenblatt, 1992; Robertson & Greenblatt, 1992). The characteristics of the homeless population have changed as well. While the homeless of the 1950s - 1970s were predominately older white males who were also alcoholic, the "new" homeless are more heterogeneous (Rossi, 1990; Roth, Toomey, & First, 1992). The homeless populations at the end of the twentieth century included more single women, more women with families, more minorities, and more individuals with mental or physical disabilities. Estimates suggest that one-third of the people living on America's streets and in homeless shelters have a severe mental illness (Rossi, 1990; Tessler, 1989); an estimated one-third consist of families (which may include mentally or physcally ill individuals) (Bassuk, 1992; Merves, 1992); an estimated one-fifth are female (which may include women with children); an estimated one-third to almost one-half have substance abuse problems (Rossi, 1990); and an estimated one-fourth have serious physical disabilities (Rossi, 1990). Note that these categories often overlap: individuals may be physically disabled, female and have small children.

In response to the growing number of homeless on California's streets, the State Legislature enacted Assembly Bill 2780, the California Statewide Supportive Housing Initiative Act (AB 2780, Statutes of 1998, Chapter 310), and Governor Gray Davis signed the bill into law. The intent of this initiative is to provide grants as an incentive and leverage for local governments, the nonprofit sector, and the private sector to invest resources that expand and strengthen supportive housing opportunities. The initiative targets very low income Californians with disabilities such as mental illness, HIV and AIDS, chemical dependency, and other chronic health conditions, or those with developmental disabilities, and may include families with children, elderly persons, young adults aging out of the foster care system, individuals exiting from institutional settings, or homeless people.

Funding for the State Supportive Housing Initiative Act (SHIA) was established in the FY 1999-2000 budget at $1 million per year for three years. A Notice of Intent to Apply (NOI), released in January 2000, drew 84 applicants. Seventeen of the top-scoring private non-profit and government agencies were invited to respond to a more detailed request for applications (RFA). After a careful and

detailed review of the RFA responses by a multi-department panel, 12 projects were selected. In early May, the panel determined the $1 million in the SHIA State Fiscal Year (SFY) 1999-2000 was sufficient to fund just seven of the projects. Then, in SFY 2000-2001, the Legislature and Governor approved a $25.1 million increase in SHIA funding (for a total of $26.1 million). In August 2000, the Director of the Department of Mental Health authorized expenditure of an additional $1 million from the new fiscal year SHIA increase to fund grants to the last 5 of the original 12 approved grant applicants. The Department of Mental Health was designated the lead agency for the Supportive Housing Initiative Act, with the responsibility to administer the grants and oversee the programs.

SHIA grant money can be used to provide both an array of supportive services to clients in housing and for the housing itself, including leasing or operating costs. The projects are required to participate in an outcomes evaluation as directed by the California State Department of Mental Health.

Description of the Projects

The twelve projects are located throughout the state, with three in Northern California, one in central California and eight in Southern California. One of the projects willserve dually diagnosed mentally ill persons; four target the seriously mentally ill; one project will provide services to men and women with developmental disabilities, and older adults with multiple disabilities; two projects will serve transition age youth who are aging out of foster care or exiting institutions; one will provide assistance to mentally ill homeless individuals who are exiting county jail; two will serve homeless skid row residents who are mentally ill, who have a substance abuse problem, or who have HIV/AIDS; and one project will serve mentally ill women. A brief description of each project is given below.

Fresno County Supportive Housing Collaborative: The primary target population served will be persons with a severe mental illness and a substance abuse disorder who are at risk of homelessness. The program is expected to serve 20 clients each year. This is a collaborative effort between the Fresno County Department of Adult Services, Turning Point of Central California, the Family Alliance for the Mentally Ill, and consumers who will provide peer support and recovery activities.

Mental Health Association in Los Angeles County: This innovative home ownership model called 'My Front Door' is sponsored by the Mental Health Association in partnership with 'The Village,' a program located in Long Beach, which is an integrated service center for persons with mental illness. Other partners include specific independent living agencies representing each disability category served – physical, mental and developmental -- who will provide support services to homeowners before, during and after purchase. This pilot

program will help individuals to purchase condominium homes in the urban city of Long Beach and rural communities located throughout the Antelope Valley.

The Marin Housing Authority, Marin County: This project will create a highly innovative service delivery team that will support the expansion of their existing Shelter Plus Care Program from 55 to 90 homeless individuals with severe mental illness. The expanded program will include additional peer case managers, physical health professionals, and an overall increase in consumer involvement. The project will also begin collaboration with Palm Court Housing to secure and lease 10 units of housing for chronically homeless individuals with severe and persistent mental illness. Other collaborative partners include the Corporation for Supportive Housing, Community Mental Health Services, the Ritter House, Homeward Bound of Marin, and Community Action Marin.

Asian Pacific Counseling and Treatment Centers, Los Angeles County: The population to be served is Asian/Pacific Islanders who have been identified by the Los Angeles County Department of Mental Health (LACMH) as high users of mental health services (a minimum of $30,000 per year). Forty housing slots will be created for residents of this project. Collaborative partners include LACMH, the City of Los Angeles Housing Authority, and the HUD-funded Shelter Plus Care.

The Arc San Francisco: The target population for this project is 75-100 men and women with developmental disabilities, including many persons 65 years of age and older with multiple disabilities. Grant funds will be used to help provide residents with access to affordable, subsidized or multiple-occupant housing, assistance in procuring housing, and linkages to programmatic support services. The Arc's collaborative partners include the City and County of San Francisco's Mayor's Office of Housing, the California Housing Finance Agency's Affordable Housing Program, the Affordable Housing Program of the California Community Reinvestment Corporation, and HUD.

San Diego County Mental Health Services: A consortium of county agencies will provide a model to meet the needs of critically underserved 18-21 year-old adults who are aging out of foster care, exiting institutions, have a mental illness, and are homeless, or at risk of homelessness. The project will help tenants locate and maintain secure, permanent, "mainstream" housing throughout San Diego. The project will screen at least 120 persons and place and support 50 residents with the help of youth consumers and youth advocates.

SHIELDS For Families, Inc., Los Angeles County: The population to be served is persons who have a mental illness, are homeless, and who are returning to the Watts and Compton communities after completing their sentences in the county jails. The project will provide housing for 40 individuals at any given time. Los Angeles is ranked 43rd out of 45 metropolitan areas on housing affordability.

Mental health treatment, case management, and substance abuse counseling, as well as medical, vocational and educational services, will be provided.

Redwood Community Action, Humboldt County: The focus of this grant project is transition age youth, ages 18-21, who are aging out of foster care in rural Humboldt county. Targeted to solve a priority community problem, it will serve 20 youth each year who have a mental illness, dual diagnosis, or substance abuse issues. This will be a model offering permanent housing options in scattered site apartments, with the youth tenants signing their own leases, or co-signing leases with Redwood Community Action. In addition, tenants may choose to live in congregate housing settings, or enroll in shared sober housing operated by Alcohol and Drug Care Services, Inc.

LAMP, Inc., Los Angeles County: The LAMP project will provide permanent housing for 129 adults with mental illness, HIV/AIDS, or substance abuse issues who are living on the streets of Skid Row in Los Angeles. This project will expand LAMP's current permanent and transition housing with additional room for 64 more tenants. LAMP will demonstrate the harm reduction model in conjunction with the twelve-step program philosophy.

St. Vincent de Paul Village, Inc, San Diego County: All residents in Village programs are homeless at the time of entry and also disabled either physically or mentally, or both. The primary source of tenants for this new project will be the transitional housing programs already operated by St. Vincent de Paul Village. This grant will support expansion of case management staff and other staff who provide programs and services to the permanent residents in 46 units of permanent housing. One of the main goals of this project is to help create a regional solution to the lack of accessible supportive housing for people with disabilities.

Homes for Life Foundation (HFLF), Los Angeles: This grant project will fund support services to 19 tenants in the Palms Court Apartments recently built by HFLF. Grant funding will provide salaries for additional staff who can give immediate assistance to tenants. Funding will also pay for a Supportive Services Coordinator to optimize provision of services to all HFLF tenants. The Homes for Life project will demonstrate how relatives and friends can join together to meet the supportive housing needs of people with mental illness. The primary focus of services is extremely low income (SSI) people with chronic mental illness who are not necessarily homeless before entering their apartments.

Ocean Park Community Center (OPCC), Los Angeles County: OPCC will provide a variety of supports, including an art and creative writing component, for women with mental illness in the city of Santa Monica. OPCC already operates a successful arts and crafts business with current consumers who retain 70% of the business' earnings. In addition to both basic and quality of life improvement

programs, this project will address special needs such as physical assault, domestic violence, and female health issues. OPCC will demonstrate the scattered site model of supportive housing in conjunction with the already-established OPCC continuum of care for female mental health consumers.

Overview of Evaluation

The goals of the evaluation are to measure the effectiveness of the Supportive Housing Initiative Projects on decreasing the social costs of homeless individuals (e.g., decrease use of emergency medical services, incarceration, and substance abuse), increasing housing stability, providing services to targeted populations, improving mental and physical health, and improving the overall quality of life for service recipients.

The evaluation design is non-experimental. Each client will serve as his/her own control, with testing at admission providing a baseline for assessing program effectiveness. Data will be collected concerning the supportive housing services each client receives, the client's symptoms, client functioning, physical and mental health status, substance use, involvement with the criminal justice system, and overall quality of life, as well as the client's satisfaction with the services received through the demonstration projects. All clients entering the supportive housing project will be eligible to participate in the evaluation.

Clients will be administered assessment instruments at admission, every six months thereafter, and at discharge. These data will be collected by project staff.

There are two assessment instruments and one Face Sheet. At admission to the program, one of the assessment forms plus the Face Sheet will be filled out. Six months later, the Face Sheet and both assessment forms will be collected. This process will be repeated every six months as long as the project continues and the client is participating in the program. When a client is discharged from the program, all three forms (face sheet plus three assessment instruments) should be completed. Data will be faxed to DMH on the day completed.

Participation by the client in the evaluation is voluntary. Clients will be asked to sign an informed Consent-To-Participate form. This consent is revocable, clients have the right to decline to participate at any point while receiving services.

Data collection at each project will be overseen by the Project Evaluator. The Project Evaluator is the key to the successful evaluation of the Supportive Housing Initiative Projects. The Project Evaluator will make sure that the data are collected on time and the forms are completed correctly. The State Evaluator from the State Department of Mental Health (DMH) will oversee the data collection at all sites and will complete the data analysis and program evaluation component, and write half-yearly reports.

Each of the Supportive Housing Initiative projects will be responsible for cost avoidance analysis of its project, as well as measuring the success in achieving each of the proposed outcomes identified by grantees in their respective proposals. Data will be collected through June 30, 2002.

Protecting Client Confidentiality

Protecting client confidentiality is very important. Client confidentiality will be protected by the use of a client identification (ID) number. This ID will be the county case number that is used to report data to the DMH Consumer Information Services (CSI) Data base. For clients without a CSI ID number, an alternative number will be agreed upon by project evaluator and state evaluator. None of the evaluation forms will contain the client's name, address, or date of birth. All forms will be linked by client ID number and date. Moreover, the clients' Consent-To-Participate forms will be kept separate from the clinical files in a locked cabinet.

Overview of Training Manual

The following chapters will provide the details about the evaluation and the data collection forms. Chapter 2 will provide an overview of the evaluation design. Chapter 3 will explain the procedures to inform the clients about the evaluation and gain consent to participate. Chapters 4 through 6 review the data collection instruments. Chapter 7 summarizes the responsibilities of the Project Evaluator. The appendices contain a list of project codes and a review of psychometric concepts.

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Chapter 2
Evaluation Design

Goals Of Evaluation

The goal of the evaluation is to measure the effectiveness of the Supportive Housing Initiative Projects in decreasing the social costs of homeless individuals (e.g., decrease use of emergency medical services, incarceration, and substance abuse), increasing housing stability, providing services to targeted populations, improving mental and physical health, and improving the overall quality of life for service recipients. Additionally, each of the Supportive Housing Initiative Projects grantees will be responsible for conducting a cost avoidance analysis for its own project, as well as measuring the success in achieving each of the proposed outcomes identified by grantees in their respective proposals.

Evaluation Design

The evaluation is non-experimental. Clients will be administered assessment instruments at admission, every six months, and at discharge. Data collected at admission will provide the baseline for assessing program effectiveness. These data will be collected by project staff.

There are two assessment instruments, plus a Face Sheet, and a Consent to Participate form. These are described briefly on Table 2.1 and in detail in chapters 3 through 6. All forms are in the public domain and there is no charge for using them.

TABLE 2.1 Brief Description of Required Housing Evaluation Forms

FORM	MEASURES	COMPLETED BY
California Quality of Life (CA-QOL)	Family/social contact; adequacy of finances; victimization; arrests; general health status; satisfaction with general life situation etc.	Client
Mental Health Statistics Improvement Program Consumer Survey (MHSIP)	Satisfaction and perceived usefulness of program services; appropriateness of services; and outcomes of care	Client
Face Sheet	Demographic background data, client living situation; project services provided to client	Project Staff
Consent to Participate	Informs clients of study goals, procedures, risks & benefits, and asks for participation	Client & Project Staff

Different assessment periods use different combinations of forms. As Table 2.2 indicates, at admission the Consent-to-Participate form, the Face Sheet and the CA-QOL will be collected. At six-month intervals, e.g., six months after admission, 12 months after admission, etc., the Face Sheet, the CA-QOL and the MHSIP Consumer Survey will be completed. At the time of discharge, the Face Sheet, the CA-QOL and the MHSIP Consumer Survey will be completed.

TABLE 2.2 Administration of Housing Evaluation Forms

ADMISSION	EVERY SIX MONTHS	DISCHARGE
Consent-to-Participate		
Face Sheet	Face Sheet	Face Sheet
California Quality of Life (CA-QOL)	California Quality of Life (CA-QOL)	California Quality of Life (CA-QOL)
	Mental Health Statistics Improvement Program Consumer Survey (MHSIP)	Mental Health Statistics Improvement Program Consumer Survey (MHSIP)

The project evaluator will prepare the forms and give them to the project staff to complete. Within **two months** of admission to the project, the Face Sheet, the Consent-to-Participate, and the CA-QOL must be completed. At six months after the admission date, the Face Sheet and both assessment forms will be completed. At 12 months, 18 months, and 24 months after admission, these forms will be completed for clients still in the program. At discharge, these three forms will be administered. The consent form is signed only once, at admission.

If the client declines to participate, he/she indicates this on the Consent-to-Participate form and the staff will complete the demographic and background items on Face Sheet for the client. **No other data** will be collected on clients who decline to participate or who are screened out. Projects with high non-participation rates will be closely reviewed.

For clients who are screened out of the project, staff will mark the appropriate bubble on the Face Sheet and then complete the demographic and background items on the Face Sheet. **No other data** will be collected on clients who decline to participate.

This process of semi-annual data collection will be repeated as long as the project continues and the client is participating in the program. When a client is discharged from the program, the Face Sheet and the two assessment instruments will be completed. If the client is unavailable for data collection at discharge, the staff will complete just the Face Sheet for the client. Data will be faxed to DMH on the day completed.

Other Data Elements

Several data elements may be collected from DMH's Client Service Information (CSI). This information will supplement the CA-QOL. This includes data on type of living situation when receiving services, types of productive activities client engages in and the number of days spent in productive activities. Clients not participating in the CSI system will not have these data.

Target Population

The target population for the Supportive Housing Initiative Projects is very low income Californians with special needs, which include mental illness, HIV or AIDS, substance abuse, chronic health conditions, or developmental disabilities, and may include families with children, elders, young adults aging out of the foster care system, CalWORKS participants, individuals exiting from institutional settings, or homeless people. Any client who enters the demonstration project will be eligible to participate in the evaluation study. There will be no selection of evaluation participants by the evaluation team.

Consent-To-Participate

CLient participation in the evaluation is voluntary. At admission, clients will be asked to sign a Consent-to-Participate form that details the goals of the evaluation, the study procedures, potential risks and benefits, the voluntary nature of participation, and steps to protect confidentiality. The consent is revocable; clients have the right to decline to participate at any point in the research. Clients also will be given a copy of the *Project Evaluation Participant's Bill of Rights*.

The decision to decline to participate in the evaluation is certainly influenced by how staff present the study to the clients. Staff should make it clear that the goal of the research is to evaluate services, not clients, and that the client's input is critical since he/she is the one receiving the services and is the person best able to evaluate the services received.

Data Collection & Reporting

Data collection on each project will be overseen by the designated project evaluator. The project evaluator will make sure that the data are collected on time and the forms are completed correctly. It will be the **project evaluator's responsibility** to get the forms faxed on the day they are completed.

Data are to be faxed on the day collected; they are not to be held until a number are available for faxing. Faxing when forms are completed ensures data are not lost and lessens the work load for the Teleform system.

The completed forms can be kept in the client's file. The project evaluator will track the completion of each set of forms and the date faxed to DMH. This tracking system will be necessary when data become lost and fail to reach DMH.

The data collection window for admission data is **60 days from the admission date**. This means that the staff have 60 days from date of admission to complete the administration of the forms. For the semi-annual data collection, the window is 6 months **after the admission collection date**. There is a 30-day window in which to collect the semi-annual data. For example, if admission data are collected on April 10th, the six-month data must be collected between October 10th and November 10th. The next data collection will be at 18 months, which would be 6 months from the date of the last data collection. For example, if the six-month data were collected on November 10th, the 18-month data collection window would be from May 10th to June 10th.

Data Analysis

DMH staff will complete the data analysis and program evaluation component.

Responsibilities of Project Evaluator

The project evaluator is the key to the successful evaluation of the project. The project evaluators are responsible for a wide variety of tasks at the project level, from preparing the forms for staff use, to ensuring timely data collection. These responsibilities are reviewed in Chapter 7.

Obtaining Forms

All the forms are in the public domain so there is no fee to purchase. A master copy of each form will be provided to the project evaluator. The project evaluator will make copies for the project. It is important that the copies be very clear and of high quality since the forms will be scanned by the Teleform system.

Chapter 3
Consent To Participate

General Information

Clients have the right to be informed of the goals of the study, to have the evaluation procedures explained, to be told about any possible benefits or risks expected from the evaluation, to be allowed to ask questions about the study, and to be allowed the choice to participate or not in the project evaluation. Clients will be informed of these rights when staff gives them a copy of the *Supportive Housing Initiative Evaluation Participant's Bill of Rights* and the *Consent-to-Participate* form. The consent will be the first form to be completed for each new client.

Administration Procedures

The Project Evaluator will give the *Consent-to-Participate* form and the *Supportive Housing Initiative Evaluation Participant's Bill of Rights* to staff with the packet of the forms that are completed at admission. **Within 60 days of admission**, the client will be told about the evaluation and asked to participate in the Supportive Housing Initiative Project Evaluation.

Staff will give the client a copy of the *Supportive Housing Evaluation Participant's Bill of Rights*. The client may keep this copy. The staff will **review each item** with the client.

Next, staff will give the client the *Consent-to-Participate* form. Staff will **review each of the items** on the consent form. Staff will explain to the client that s/he has the right to refuse to participate in the study. The client must be told that if s/he refuses to participate in the study, this will not affect his/her ability to receive services from the Supportive Housing Initiative Project.

If a client is reluctant, s/he should be given time to think about this. It may be helpful to use a peer advocate to explain and discuss the project with a reluctant client. In mental health settings, there are often peer advocates who can discuss and review issues on a one-to-one level with project participants. With other populations, a participant in the project may be able to help administer the forms. While clients must not be coerced, it is desirable that as many as possible participate in the evaluation. The evaluation is their opportunity to provide feedback about their needs and about project effectiveness.

Once it is clear that the client understands the rights, the staff will ask the client if s/he wants to participate. If the client agrees to participate, the client will sign and date the form, and the staff will sign as a witness and date it as well.

Declines to Participate

If a client declines to participate, the staff will write across the bottom of the form, "Declines" and the client will be asked to sign next to the handwritten "Declines." Note that a client who declines does not sign on the client's signature line; to sign on that line gives consent. Staff will sign and date the forms of clients who decline.

Maintaining Consent Forms

Since the Consent-to-Participate contains the client's name, the form will not be forwarded to DMH. The project evaluator will keep all the Consent-To-Participate forms in a single file. This file may be examined from time to time by the DMH state evaluator. When the file is examined, the project evaluator will obscure the names of clients, thus protecting client privacy.

Obtaining Forms

The State DMH will provide a clean copy of the *Supportive Housing Initiative Evaluation Participant's Bill of Rights* and the *Consent to Participate* form. The project evaluator will make clear copies to distribute to staff.

SUPPORTIVE HOUSING INITIATIVE EVALUATION PARTICIPANT'S BILL OF RIGHTS

Any person who is asked to consent to participate as a client in the Supportive Housing Evaluation, or who is asked to consent on behalf of another, has the following rights:

1. To be told what the study is trying to find out.

2. To be told the procedures to be followed in the evaluation and whether any of the procedures are different from those which are carried out in standard practice.

3. To be told about the risks, adverse effects, and discomforts which may be expected.

4. To be told of any benefits the participant may expect from participating.

5. To be told of other choices available and how they may be better or worse than being in the study.

6. To be allowed to ask any questions concerning the study both before consenting to participate and at any time during the course of the study.

7. To be told of any medical treatment available if complications arise.

8. To refuse to participate at all, either before or after the study has begun. This decision will not affect any right to receive standard services.

9. To receive a signed and dated copy of the consent form and the Bill of Rights.

10. To be allowed time to decide to consent or not to consent to participate without any pressure being brought by the investigator or others.

CONSENT TO BE A RESEARCH PARTICIPANT IN _____ PROJECT'S SUPPORTIVE HOUSING INITIATIVE EVALUATION

Goal of Study

The goal of the evaluation is to measure how effective the Supportive Housing Initiative Project is at improving your functioning and the overall quality of your life. (Name of project evaluator) and the State Department of Mental Health are conducting this evaluation. You have been asked to take part in this evaluation because you are receiving services from the Supportive Housing Initiative Project. The study will last three years.

Study Procedures

If you agree to participate, this is what will happen:

1) The project staff will provide the evaluators with demographic information about you (e.g., age, gender), background information, and information about services received from the Supportive Housing Initiative Project. This information will not include your name but will contain a client ID, which will identify your information for the evaluation.
2) You will be asked to fill out the California Quality of Life form. This form asks you to rate your satisfaction with several aspects of your life. This form takes approximately 20-30 minutes to complete. This form will be sent to the evaluators. Again, it will not give your name, but will use a client ID number.
3) A project staff member will assess your mental and physical health symptoms and provide this information to the evaluators. Again, the form will not contain your name but will use your client ID number
4) After you have been in the program for six months, you will be asked to fill out a consumer satisfaction survey in order to find out if you are satisfied with the services you are receiving in the Supportive Housing Project. Again, the form will not contain your name but will use your client ID number. This form takes approximately 10 minutes to complete. This form will be mailed directly to the State Department of Mental Health evaluator.
5) Every six months thereafter, while you are in the project, you will be asked to fill out all the forms and project staff will provide background information to the evaluators. Again, the forms will not contain your name but will use a client ID number.
6) This same information, with the exception of the satisfaction survey, is collected routinely when you receive mental health services. The only difference is that this information will be collected together with the same information from other clients of the supportive housing project in order to evaluate the services that are being provided.

Risks

The primary risk to you from participating in the study is that someone not on the evaluation team might see confidential information about you. For example, someone might see the forms you complete. To protect against this, we are using a client ID number instead of your name. Also, the consumer satisfaction survey you fill out will be mailed directly to the State Department of Mental Health Evaluator so that any critical

comments you make about the services received in the Supportive Housing Project will not be read by project staff. This information will be put together with information from other clients in the project and shared with project staff in a summary form so that comments cannot be linked to any individual.

You may experience some discomfort (such as anxiety or frustration) when asked personal questions. Staff will assist you if you become upset by such questions.

Potential Benefits

Your participation in the evaluation may benefit you by providing treatment and services in a more efficient and timely manner. The information you provide may benefit you by helping staff understand you better. Your comments may help improve the services provided. Your participation in the evaluation may not benefit your directly, but the information may be helpful in planning and reviewing the types of services provided to others in the future.

Questions

If you have other questions or evaluation related problems, you may contact (name of project evaluator) at (telephone number).

Voluntary Participation

Participation in this evaluation is entirely voluntary. You may refuse to participate or withdraw from the evaluation at any time. If you choose not to participate, your refusal will have no effect on your ability to receive services from the Supportive Housing Project.

Confidentiality

Evaluation information will be kept separate from any other records. You will be assigned a client ID number which will be used for all of the study information and will protect your confidentially to the extent provided by law. This Consent-to-Participate form will be kept by project evaluator, (name of project evaluator). It may be reviewed by the state evaluator but no one else will have access to this information.

Consent

Your signature below gives your consent to participate in the Supportive Housing Evaluation study. It also confirms that you have been given a copy of the "SHIA Evaluation Participant's Bill of Rights" that describes your rights as a participant in this study. If you decline to participate, please write "Decline" across the bottom of the page and put your initials next to it.

_____ _____

Client's signature Date Print Name

_____ _____

Legal Representative if necessary Staff witness signature Date

Chapter 4
Face Sheet

General Information

The Face Sheet is the second form that will be completed for a client. This form will provide background information about the client, including ethnicity, gender, current living and employment situation. It will also ask for information about services the client has received from the Supportive Housing Initiative project. The Face Sheet will be filled out for each client who consents to participate. For clients who do not consent to participate, part of the Face Sheet will be filled out (details described below).

The Face Sheet will be completed for each client at admission, every six months thereafter, and at discharge. This form is completed by staff. At admission, data on the demographic characteristics of the client will be collected, as well as data on the client's physical and mental health status, employment status, criminal justice involvement (victim/suspect/arrestee), and housing status. At subsequent administrations (every six months and at discharge), these same data will be collected again, along with information on services received from the Supportive Housing Initiative Project. Demographic data will only be collected at admission. Each time the Face Sheet is completed, it will be faxed to the State DMH for automated entry into a computerized database.

Development

The Face Sheet was developed specifically for the Supportive Housing Initiative Projects. It was designed to get basic information on each client without creating a heavy work load for project staff. It uses the Teleform system which will speed data analysis.

Form Completion

The Face Sheet will be completed at every data collection. Before the Face Sheet is given to the staff to complete, the project evaluator will enter the correct client identification (ID) number, project code, distribution date, and assessment type in the appropriate fields. These items are described below.

Client ID: This is the project case number for the client as reported to CDS/CSI. The client's idenfication number be written in the boxes under "Client ID Number" and then the appropriate circles should be marked below. It is critical that this number be correct. If the client does not have a CDS/CSI number, staff will use Social Security Number (SSN). Client ID will also be entered on the

bottom of **each** page in the row of nine boxes. It is critical that this number be entered correctly on all pages.

Client Ethnicity: The client's ethnicity should be based on client's self-identification. Staff will fill in the appropriate bubble for ethnicity. Like other demographic characteristics, this is only completed on the first Face Sheet, at admission.

Client Age: The client's age should be age at the time of scheduled administration (i.e., distribution date). Staff will enter the age in the boxes and fill in the circles below with the number. This information will be collected only once, at admission.

Client's Gender: Client's gender refers to client's self-identification. Staff will fill in the appropriate bubble for gender. Note that gender is only collected once, at admission. On subsequent data collections, demographic and background information will not be collected when completing the semi-annual and discharge Face Sheets.

Assessment Type: The evaluator will mark the appropriate circle for "Assessment Type." At admission, the evaluator will mark "Admission." At the semi-annual review (every six months after admission), the evaluator will mark "Semi-Annual." When the client is discharged, the evaluator will mark the "Discharge" circle.

Note that some clients may decline to participate when asked. The evaluator has no way of knowing this in advance. Thus, the item in the shaded box "Refused to participate" will **never** be filled out by the evaluator. Project staff will mark this choice if a client declines, and erase the assessment choice marked by the evaluator. Likewise, a client may be mentally incapable of completing the self-administered forms, but the evaluator has no way of knowing this in advance. Thus, this item will be completed by staff; it will **never** be filled out by the evaluator. Staff will determine if a client is unable to complete the forms on his/her own or with help from a peer advocate. If the staff determine that the client is truly mentally incompetent (due to cognitive deficits or mental illness), the client can be screened out of the evaluation project.

Project number: Enter the project number. This number is a research number assigned by the state evaluator. Enter the number in the boxes and then mark the appropriate circles. See appendix A for project codes.

Distribution Date: Next, the evaluator should complete the field "Distribution Date." This date, along with client ID, is used to link the forms for any given assessment. This date is the date the forms are given to the staff, not the date the forms were completed. This date **must be the same** on all of the forms for a given administration. For example, at admission both forms (Face Sheet and CA-

QOL) must have the same distribution date. The evaluator will write the distribution date in the boxes and then fill in the corresponding circles.

Client's Marital Status: Marital status may be a good predictor of outcomes. Staff will choose the description that best describes the client's marital status at the time of admission to the program.

After these fields are completed, the evaluator will give the Face Sheet, along with the CA-QOL form that must be completed, to the project staff for completion. The Face Sheet will be completed by project staff within 60 days of the client's entering the program. Note that the time frame is not 60 days from the time the staff get the forms to complete; it is 60 days **from client admission**. Staff will be responsible for completing the rest of the Face Sheet. These items are described below.

Assessment type revisited: If a client declines to participate, project staff will erase the choice of "Assessment Type" marked by the project evaluator, and will fill in the bubble for "refused to participate" on shaded section of the Face Sheet. This is one of only two times that project staff will complete Assessment Type. The other time is when clients are mentally incapable of completing the client-completed forms. In these cases, the staff will mark "screened out." For clients who decline or are screened out, the staff will then complete the rest of the demographic items (age, ethnicity and age) and diagnostic items (i.e., primary mental health diagnosis, substance abuse diagnosis, and client's special needs). This information will permit the state DMH to describe the characteristics of those who are excluded from the evaluation to see if they differ significantly from those who participate. No other data will be collected on those who are excluded and no additional forms (e.g., discharge) will be completed.

Mental Health Diagnoses: If client has no diagnosed mental problems, select the response, "Not applicable - no known mental health problems." For those with a diagnosis, chose the appropriate diagnostic category. This information will be collected only once, at admission.

Substance Abuse Diagnosis: If the client has no diagnosed substance abuse problems, select the response "not application - no substance abuse problem." For those with a diagnosis, chose the appropriate diagnostic category. This information will be collected only once, at admission. The "unknown" category should be used sparingly.

Client's Special Needs: To be eligible for the SHIA projects, clients must be very low income Californians with special needs. The staff will mark the "yes" bubbles for all those conditions that that they know the client has. Naturally, this would include the special needs that qualify the client for the SHIA programs. Additionally, it could include other special needs as well. For example, a SHIA

project is targeting homeless mentally ill people and a client is admitted who is a homeless mentally ill woman with AIDS. The staff would mark the "yes" bubble next to mental illness and the "yes" bubble next to homeless and the "yes" bubble next to AIDS. Note that staff only marks those items that s/he knows about, the staff do not have to interview the client to determine how many special needs the client might have. The idea is to identify the main special needs that staff know about. The staff will then mark the "No" bubbles for all those items that are not special needs of the client. This information will be collected only once, at admission.

History of Chronic Physical Health Problems: Select the one response that best describes the client's history of physical health problems. This information will be collected only once, at admission.

History of Homelessness: Select the one response that best describes the client's history of homelessness. You may have to ask the client for this information. This information will be collected only once, at admission.

History of Mental Health Treatment: Select the response that best describes the client's history of mental health treatment. If they have no history, fill in the "Not applicable" bubble. This information will be collected only once, at admission.

History of Substance Abuse Treatment: Select the response that best describes the client's prior experience with substance abuse treatment. If they have no history, fill in the "Not applicable" bubble. This information will be collected only once, at admission.

Criminal History: Staff will chose the option that best describes the client's criminal justice experiences. This information will be collected only at admission.

Employment History: Staff will chose the option that best describes the client's employment history. This information will be collected only at admission. Information on a client's current employment status will be collected elsewhere.

Employment status: Staff will choose the **one** response that most closely describes client's **current** employment status. Current refers to employment status at the time of scheduled administration (i.e., distribution date). Note that a client may logically be described having two or more of the statuses. For example, a client be employed in the competitive job market and also be actively looking for work, and also is a student. However, these three responses are meant to be **mutually exclusive.** We are interested in the client's employment status or lack of employment. If the client is employed, that option should be chosen first,rather than the optin "CLient is not in the job market." It is the evaluator's job to make sure that the staff only select one of the three responses. This information will be completed by staff every time a Face Sheet is filled out.

Project Services: This item will be completed semi-annually and at discharge. The section is **not** completed at admission. Staff will select the item that most closely describes the services the client has received from the Supportive Housing Project up to the time of the data collection.

Previous Living Situation: On the admission Face Sheet, staff will skip this item. On the semi-annual and the discharge Face Sheets, the staff will select the description that best describes the client's living situation in the prior year and enter the appropriate letter in the box under "Previous Living Situation."

Current Living Situation: Staff will select the description that best describes the client's living situation at the time of administration of the form (i.e., distribution date) and enter the appropriate letter in the box under "Current Living Situation." Note that if the client has not changed his/her living situation since the last assessment, both current and previous living situation items will be coded the same.

Previous Tenancy Status: On the admission Face Sheet, staff will **skip** this item. On the semi-annual and the discharge Face Sheets, the staff will select the status that best describes the client's previous tenancy status and fill-in the corresponding circle.

Current Tenancy Status: Staff will select the description that best describes the client's current tenancy status and fill-in the corresponding circle. Current refers to the client's status at the time of the scheduled administration (i.e., distribution date).

Faxing Forms to DMH

On the day the Face Sheet is completed, staff will fax it to the State DMH Teleform number, 916-654-3178. Note that this FAX number is just for Teleform instruments.

Obtaining Forms

The State DMH will provide a clean copy of the Face Sheet to the project evaluator. The project evaluator will make clear copies of the Face Sheet to distribute to staff.

7660

Supportive Housing Iniative Act (SHIA) Face Sheet

CLIENT [redacted]ER

0 1 2 3 4 5 6 7 8 9 A B C D E F G H I J K L M N O P Q R S T U V W X Y Z

Client Ethnicity:
- O White/Caucasian
- O Hispanic
- O African American
- O Asian/Pacific Islander
- O Filipino
- O Native American
- O Other
- O Unknown

Client Age

1 2 3 4 5 6 7 8 9 0

Client's Gender
- O Male
- O Female
- O Unknown

Assessment Type
- O Admission
- O Semi-Annual
- O Discharge
- O Refused to Participate
- O Screened Out

Project Code

1 2 3 4 5 6 7 8 9 0

[redacted]

1 2 3 4 5 6 7 8 9 0

Marital History
- O Currently Married
- O Divorced
- O Widowed
- O Current Live-In Relationship/Significan Other/Same Sex Relationship
- O Never Married
- O Unknown

Client's Primary Mental Health Diagnosis
- O Schizophrenia and other Psychotic Disorders
- O Mood disorders (i.e., major depressive or bipolar disorders)
- O Anxiety/Other Diagnoses
- O None

Subustance Abuse Diagnosis
- O Problems With Alcohol
- O Problems With Drugs
- O Problems With Both Alcohol and Drugs
- O Not Applicable - No Alcohol or Drug Problems

(1.) *Client's Special Needs:*

	Yes	No
a. Severe and persistent mental illness	O	O
b. Substance abuse problem	O	O
c. Developmental disabilities	O	O
e. Physical Disabilities (e.g., quadripelegic, blind)	O	O
f. AIDS	O	O
g. TANF client	O	O
h. Foster care client aging out of foster care	O	O
i. Exiting jail/prison	O	O
j. Other: _____ (please specify)	O	O

(2.) *History of Chronic Physical Health Problems*
- O Minor chronic physical health problems that cause minimal impairment in functioning (e.g., mild asthma, epilepsy, hearing problem corrected with a hearing aid).
- O Moderate physical health problems which cause some difficulty in functioning (e.g., moderate hypertension, mild cerebral palsy; problem requires medical follow-up several times a year).
- O Serious chronic physical health problems which causes serious impairment in mobility, speech, vision, etc, despite use of glasses, hearing aids, etc.
- O Major physical health problems - confined to bed or wheelchair most of the time (e.g., advanced cancer, cerebral palsy).
- O Not Applicable - no chronic physical health problem
- O Unknown

Client I.D.

7660

7660

3. *History of Homelessness:*

- O Currently at risk for homelessness
- O Homeless, first experience, homeless less than one year
- O Homeless, homeless several times before
- O Homeless for long period of time (i.e., more than one year)
- O Never homeless
- O Unknown

4. *History of Mental Health Treatment*

- O No history of treatment despite presence of mental illness
- O Some experience with mental health services
- O Prior hospitalization or inpatient services
- O Lengthy experience with Mental Health services, but no hospitalization
- O Lengthy experience with Mental Health services, including hospitalization
- O Not applicable - no mental health problem
- O Unknown

5. *History of Substance Abuse Problems*

- O Minor substance abuse problems, no treatment history
- O Serious substance abuse problems, no treatment history
- O Substance abuse problems with some involvement in a treatment program
- O Substance abuse problems with repeated involvement in treatment programs
- O Not Applicable - No substance abuse problems
- O Unknown

6. *Criminal History*

- O Minor arrest history - nuisance offenses (drunk, disturbing peace, etc.)
- O Several arrests (misdemeanor) and time spent in jail
- O Serious arrests (felony) and spent time in jail/probation
- O Serious arrests (felony) and spent time in state prison
- O Not Applicable - No involvement with the criminal justice system
- O Unknown

7. *Employment History*

- O Minimal employment history (e.g., a few part time jobs, or one full time job)
- O Sporadic work history (e.g., mixture of full time jobs or part-time jobs and periods of unemployment)
- O Substantial work history (e.g., worked several years at a full time job, or several full time jobs in the same field)
- O None (never employed)
- O Unknown

Client I.D.

7660

7660

(8.) *Client Employment Status (choose one)*

- O **Client is employed in the competitive job market**
  If yes, approximately how many hours per week:
  O Less than 35 O 35 or more
- O **Client is employed in the noncompetitive job market (sheltered workshop, protected environment)**
  If yes, approximately how many hours per week:
  O Less than 35 O 35 or more
- O **Client is not in the job market. Client is (choose one)**
  - O Actively looking for work
  - O Homemaker
  - O Student
  - O Volunteer Worker
  - O Retired/on disability
  - O Resident/inmate of institution
  - O Other
  - O Client employment status is unknown

(9.) Services client has received from this Supportive Housing Project since the last assessment (if admission assessment, skip this section):

- O Housing Services
- O Referral to commnity mental health services
- O Screening and diagnostic services
- O Referrals to drug/alcohol treatment services
- O Client declined any services
- O Case Management services
- O Planning for/referral to housing
- O Assistance in applying for housing
- O Helped client obtain housing (e.g., assistance in filling out lease agreement; help w/deposit)
- O Assistance in maintaining housing (e.g., assistance to prevent eviction)

Client I.D.

7660

7660

10a. Client's Previous Living Situation (Select code from list below) (If admission, skip this item)

☐

10b. Client's Current Living Situation (select code from list below)

☐

- **A** House or apartment (include trailers, hotels, dorms, barracks, etc.)
- **B** House or apartment and requiring some support with daily activities
- **C** House or apartment and requiring daily support and supervision
- **D** Supported housing
- **E** Foster family home
- **F** Group Home (includes levels 1-12 for children)
- **G** Residential Treatment Center (includes levels 13-14 for children
- **H** Community Treatment Facility
- **I** Board and Care
- **J** Adult Residential Facility, Social Residential Facility, Crisis Residential, Traditional Residential, Drug Facility, Alcohol Facility
- **K** Mental Health Rehabilitation Center (24 hour)
- **L** Skilled Nursing Facility/Intermediate Care Facility, Institute of Mental Disease (IMD)
- **M** Inpatient Psychiatric Hospital, Psychiatric Health Facility (PHF), or Veterans Affairs Hospital
- **N** State Hospital
- **O** Justice related (Juvenile Hall, CYA home, correctional facility, jail, etc.)
- **P** Homeless, no identifiable residence
- **Q** Other
- **U** Unknown/Not reported

11a. Previous Tenancy Status (at time of last assessment; if admission, skip this item)

- ○ Continuing
- ○ Evicted due to lease violations
- ○ Left voluntarily
- ○ Other
- ○ Unknown

11b. Current Tenancy Status (at time of this assessment)

- ○ Continuing
- ○ Evicted due to lease violations
- ○ Left voluntarily
- ○ Other
- ○ Unknown

Client I.D. ☐☐☐☐☐☐☐☐☐

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Chapter 5
California Quality Of Life
(CA-QOL)

General Information

The California Quality Of Life (CA-QOL) measures the client's satisfaction with his or her quality of life. The eight domains covered include general life satisfaction, living situation, daily activities and functioning, family, social relations, finances, legal and safety, and health. The form is designed to be completed by the client in approximately 20 minutes.

Development

The CA-QOL was developed in response to a need in another DMH project (The Adult Performance Outcome System) for a self-administered quality of life assessment instrument in the public domain. DMH obtained permission from Dr. Anthony Lehman to select and modify items from two of his instruments, Lehman's Quality of Life Long Interview and Lehman's Quality of Life Brief Interview. A committee composed of representatives from California's Department of Mental Health, Project Mental Health programs, California Mental Health Planning Council, and additional consultants was formed to develop a short self-administered quality of life assessment instrument. The CA-QOL was constructed statistically from items in Lehman's two instruments. After its development, the form was pilot tested. The CA-QOL, in combination with information from the state DMH CSI system, measures the same domains as Lehman's self-administered form (Lehman's QOL-SF).

Psychometrics

The psychometric properties, reviewed during the pilot testing for the Adult Performance Outcome Pilot Evaluation, are acceptable. See Appendix B for a review of psychometric concepts.

Reliability: The overall reliability of the CA-QOL is high (.93). The reliability of all CA-QOL subjective scales is relatively high (.84 to .93), while the reliability of the three CA-QOL objective scales with more than 1 item is modest (.67 to .75). The reliability coefficients of the same three objective subscales are also modest (.73 - .76).

Validity: The CA-QOL was developed from two of Lehman's Quality of Life forms and these two forms have demonstrated validity. By extrapolation, the CA-QOL is assumed to be valid.

Differential Functioning: An analysis of subscale scores by demographic category indicated statistically significant differences at the .05 level. These differences, although significant, were deemed minor because they accounted for only 10% of the variance.

Diagnoses combined: When all diagnoses were combined, statistically significant differences were found, but these were minor.

Within Diagnoses: When stratified by diagnoses, statistically significant differences were found. For Diagnosis 1 (Schizophrenia/Psychotic Diagnoses), there were significant differences for the category age on two scales: "General Life Satisfaction" and "Satisfaction with Living Situation." Post hoc tests did not pinpoint these differences as explained above. However, the youngest and oldest groups had higher mean scores than did the intermediate age categories.

For Diagnosis 2 (Mood Disorders), there were statistically significant differences on three objective scales. Differences were found for age for "Amount of Spending Money." Clients in the youngest age category reported having less money to spend on themselves than did clients in the other age categories. There were also differences on "Adequacy of Finances." The youngest and oldest age categories reported having the least money for various items. It is possible that these differences could be an artifact of low numbers.

There was a meaningful difference found for ethnicity on "General Health Status." Although post hoc tests did not pinpoint these differences, Asians tended to have the highest mean scores and Caucasians the lowest mean scores. It is possible that these differences could be an artifact of low numbers.

Scoring

Scoring of the CA-QOL is relatively straightforward. Items can be scored individually or as part of a scale score. Computing scale scores consists primarily of calculating averages for scales with more than one item. There are two types of items: subjective items and objective items. All subjective items use the same 7-point scale. Objective items use a variety of formats. Scale scores can be computed for each type. An overall quality of life score would not be appropriate because of the varying item content and format.

The specific items comprising each of the scales can be found in the "Scoring Manual for the California Quality Of Life," which is included at the end of this chapter.

Clinical Utility

The CA-QOL provides a relatively brief, structured way to assess self-reports of the quality of life for persons with severe mental illness. The instrument provides both an objective measure about a quality of life indicator as well as the client's

subjective feelings of satisfaction about that indicator. The CA-QOL results can provide useful information for assessment and treatment planning, e.g., assessing a client's satisfaction with qualify of life, developing a baseline for satisfaction with quality of life, etc.

Administration Procedures

The CA-QOL is completed at every data collection, i.e., at admission, every six months, and at discharge. The project evaluator will complete the top portion of the form by filling in the fields for "Client ID Number," "Distribution Date," and "Project Code." Also, the Client ID should be entered in eight of the boxes at the bottom left-hand corner of each page of the form. These items are completed in the same way as on the Face Sheet, see Chapter 4, "Administration Procedures." After this is completed, the project evaluator will give the form to project staff so they can give it to the client to complete.

Within the first 60 days following admission, project staff will give the CA-QOL to the client to complete. This form takes approximately 18 minutes for clients to complete on their own. In the pilot test, 60% completed the instrument without assistance, approximately one-quarter required some assistance (23%), and 15% required total interviewer administration.

When the client has completed the form, the staff will fax it to DMH on the day it is completed.

Overlap with Performance Outcome Project

The CA-QOL is being used for the Performance Outcome project so it is possible that a client will have a recently completed CA-QOL in file. If the CA-QOL has been completed for the client within 30 days of the distribution date, the staff may, if they wish to, copy the scores onto the Supportive Housing Teleform sheet. The Teleform sheets for different projects are **not** interchangeable.

Discharged Client Unavailable

There will be times when a client is discharged because she/he has left the program without advance warning and is unavailable to complete the CA-QOL. Some of these clients will simply disappear; others will be incarcerated or hospitalized. Every attempt should be made to get all the forms completed. However, if the client is unavailable, the CA-QOL will not be collected.

Faxing Forms to DMH

On the day the CA-QOL is completed, staff will fax it to the State DMH Teleform number, 916-654-3178.

Obtaining Forms

The State DMH will provide a clean copy of the CA-QOL Teleform to the project evaluator. The project evaluator will make clear copies of the CA-QOL to distribute to staff.

Scoring Manual

for the

California Quality of Life (*CA-QOL*)

Prepared by the California Department of Mental Health
Research and Performance Outcome Development Section

Table of Contents

Tables

ACKNOWLEDGMENTS

The California Department of Mental Health would like to express its appreciation to the California Mental Health Directors Association and the California Mental Health Planning Council for their support and assistance in the development and implementation of the Adult Performance Outcome System, of which this manual is a part. Additionally, we would like to express our gratitude to the leadership, staff, and mental health consumers of Sacramento and San Mateo counties for their assistance in the development of the California Quality of Life (*CA-QOL*) Survey. We would also like to thank Dr. Anthony Lehman, Department of Psychiatry, University of Maryland, for his permission to use items from his public domain quality of life instruments in order to develop a survey instrument particularly suited to California's needs.

For more information about the *CA-QOL* contact:

California Department of Mental Health
Research and Performance Outcome Development Unit
1600 9th Street
Sacramento, California 95814

Scoring Manual for the California Quality of Life

I. BACKGROUND

Introduction

Under the leadership of the State Department of Mental Health (DMH), the California Mental Health Planning Council (CMHPC), and the California Mental Health Directors Association (CMHDA), a pilot project was conducted to assess instruments for use in California's Adult Performance Outcome System. The recommendation that resulted from this pilot was that the following instruments be selected for statewide implementation: the Global Assessment of Functioning (*GAF*) Scale, the Behavior and Symptom Identification Scale (*BASIS-32*), a quality of life survey instrument, and a consumer satisfaction program evaluation instrument.Further meetings regarding a quality of life instrument resulted in the selection of the *QL-SF* (formerly called the *TL-30S*), Dr. Anthony Lehman's shorter, self-administered quality of life instrument. Additionally, in order to respond to subsequent questions about the availability and cost of the *QL-SF* and to provide greater flexibility to the counties, the DMH, CMHPC, and CMHDA agreed to develop an alternative, self-administered, public domain quality of life instrument (the California Quality of Life or *CA-QOL*). If the *CA-QOL* proved sufficiently comparable to the *QL-SF*, counties could, at their discretion, choose to use either quality of life instrument for the Adult Performance Outcome System.

Development of the *CA-QOL*

DMH obtained written permission from Dr. Lehman to select and modify items from his public domain Quality of Life Interview Instruments (*QOL-Brief* and *QOL-Long*) in order to develop a new quality of life instrument particularly suited to California's needs. A small committee of representatives from DMH, CMHPC, and CMHDA then developed a draft of the new quality of life instrument, the *CA-QOL*, extracting items from both the *QOL-Brief* and *QOL-Long*.

The *CA-QOL* consists of 40 items and measures the same domains as the *QL-SF* when supplemented with information from DMH's Client Services Information (CSI) data system. In order to minimize the data collection burden on counties, while measuring the CMHPC domains, the committee agreed to obtain as much data as possible from the CSI system.

Pilot Methodology

Two counties (Sacramento and San Mateo) volunteered to administer both quality of life instruments to a sample of seriously mentally ill adult mental health clients. The counties attempted to obtain a heterogeneous sample with particular emphasis on obtaining adequate numbers of both men and women. Information was also gathered on the client's ethnicity and age, as well as primary diagnosis within broad categories. Categories of diagnosis found to be useful in the previous pilot were: (1) schizophrenia and other psychotic disorders, (2) mood disorders, and (3) anxiety and other diagnoses. Pilot protocols were developed and distributed before the counties began administering the instruments. These protocols addressed clinician training, instrument administration issues, and data collection and reporting issues

Pilot Results

Both instruments were administered in a rotated order to a sample of 198 seriously mentally ill adult mental health clients. In general, pilot participants included adequate numbers within age categories, major ethnic groups, gender, and the two major diagnostic categories to allow for statistical analysis. There was little missing data.

Most client participants were able to complete either of the instruments without assistance (approximately 60%). Approximately 23% of the clients required some assistance and only about 15% required total interviewer administration. On average, it took clients 20 minutes to complete the *QL-SF* and 18 minutes to complete the *CA-QOL*. The range of reported times for both instruments was from about five minutes to as long as one hour. Approximately 75% of the clients were able to complete either instrument in 20 minutes or less, and approximately 90% of the clients were able to complete either instrument in 30 minutes or less. Completion times for both instruments could vary considerably depending on the client's level of functioning.

In general, average scores on corresponding scales were quite similar and correlated well. An analysis of scale scores by demographic category indicated only minor statistically significant differences.

Based on an internal consistency measure of reliability (Cronbach's alpha), the overall reliability of the *CA-QOL* was found to be high (.93), while the overall reliability of the *QL-SF* was lower (.70). The reliability of the three *CA-QOL objective* scales with more than one item was modest, as was the reliability of the same three *QL-SF* objective subscales. The reliability of all *CA-QOL subjective* scales was relatively high. The reliability of *QL-SF* subjective scales can only be computed for the two items which make up the "General Life Satisfaction" scale, and it was slightly lower than for same two items on *CA-QOL*. Internal

consistency coefficients of reliability cannot be computed for any other *QL-SF* subjective scales since the other scales have only one item.

Both instruments were based on Lehman's *QOL-B and QOL-L* instruments, which have demonstrated validity and reliability. By extrapolation, it is assumed that the *QL-SF* and *CA-QOL* are valid. Additionally, the instruments are assumed to be valid for purposes of the California Adult Performance Outcome System because they measure what they are supposed to measure; i.e., the CMHPC quality of life domains.

For more detailed information on statistical results, a copy of the summary report entitled "A Pilot to Evaluate Alternative Quality of Life Assessment Instruments," can be obtained by writing the California Department of Mental Health, Research and Performance Outcome Development Unit, 1600 9th Street, Sacramento, California, 95814.

Conclusions of Pilot

In many ways the instruments are similar:

- Both instruments provide a relatively brief, structured way to assess the quality of life of persons with severe mental illness.
- Both instruments are based on Lehman's public domain quality of life instruments and, as a result, item content and format are similar.
- When combined with the CSI data system, both instruments adequately measure the quality of life domains which are of interest to the CMHPC.
- The completion time required and assistance needed were similar for both instruments.
- There was little differential impact within scales of either instrument.
- Mean scores are quite similar for corresponding scales, and correlations between these scales are generally high. No meaningful differences were found between scale scores across instruments. Scores from the *QL-SF* can be statistically equated to those on the *CA-QOL* using regression techniques.

In some ways the CA-QOL has advantages for California:

- The *CA-QOL* is in the public domain. This not only eases the financial burden on counties, but makes it possible to revise the instrument's format or develop language translations to meet California's needs.

- An analysis of the psychometric properties of the *CA-QOL* indicates it compares very favorably with the *QL-SF*. It is somewhat faster to complete, and its overall and scale reliability based on internal consistency is better.

- The *CA-QOL* minimizes the data collection burden on counties, while still measuring the CMHPC domains, by obtaining as much data as possible from California's CSI data system. However, although this eliminates redundant questions, it also limits the instrument's usefulness for national comparisons because certain data elements are missing.

- Although both instruments, when combined with CSI data, measure the same CMHPC domains, the *CA-QOL* provides more complete information on the subjective, client satisfaction scales.

The purpose of the pilot was to determine whether the *CA-QOL* and *QL-SF* could be equated and to analyze the psychometric properties of the two instruments. After a review of the initial pilot results, the conclusion of this project is that the *CA-QOL* can serve as a valid alternative to the *QL-SF*. Additional data are still being gathered and will be appended when they are available.

II. GENERAL GUIDELINES

Clinical Integration

The key to the successful implementation of the adult performance outcome measurement system is effective clinical integration of the performance outcome instruments. The *CA-QOL* is one part of a set of instruments. The information provided by the set of outcome instruments can furnish valuable clinical information. However, unless clinicians understand how to interpret and integrate this information into the diagnosis, treatment planning, and service provision process, the data will not be used effectively.

The results of the adult performance outcome instruments are not intended to replace the skills used by clinicians to complete a thorough evaluation, design a treatment plan, or monitor progress. Many of the questions are similar to the questions clinicians already ask as part of their clinical assessment. However, asking these questions in a standardized format, in combination with clinical assessment skills and additional data sources, gives a more comprehensive and objective clinical profile of an individual client.

Uses

The *CA-QOL* results can provide useful information for assessment and treatment planning (e.g., assessing a client's satisfaction with quality of life, developing a

baseline for satisfaction with quality of life, identifying areas of strength or weakness, and developing a treatment plan). The *CA-QOL* results can also be useful for monitoring/evaluating progress, identifying a need for additional resources, and evaluating the effectiveness of treatment.

Administration

The *CA-QOL* should be administered along with the other assessment instruments at intake (once a client has been determined to be part of target population), yearly, and at discharge. The Adult Performance Outcome Training Manual gives more specific information on administration procedures for the adult performance outcome instruments. A copy of the Adult Performance Outcome Training Manual can be obtained by writing the California Department of Mental Health, Research and Performance Outcome Development Unit, 1600 9th Street, Sacramento, California, 95814.

As indicated earlier, the *CA-QOL* was intended to be administered as a self-report, but the pilot found that assistance may be required. This assistance does not necessarily have to be provided by the clinician.

III. SCORING THE *CA-QOL*

Scoring of the *CA-QOL* is relatively straightforward. Items can be scored individually or as part of a scale score. Computing scale scores consists primarily of calculating averages for scales with more than one item. There are two types of items: subjective items and objective items. All subjective items use the same 7-point scale. Objective items use a variety of formats. Scale scores can be computed for each type. An overall quality of life score would not be appropriate because of the varying item content and format.

The specific items comprising each of the scales are listed in Table 1 below. *Note*: scoring of the alternate quality of life instrument, the *QL-SF*, is also relatively simple. Counties selecting the *QL-SF* can obtain a scoring manual by contacting Deborah Rearick of HCIA/Response at (781) 522-4630 or writing HCIA/Response Technologies at 950 Winter Street, Waltham, MA, 02451.

Missing Data

Scale scores should not be computed if there are any missing data for that scale. Because most scales are composed of no more than two or three items, even a single non-response to the items in that scale significantly affects an aggregated score.

Subjective Scales

All of the items measuring subjective scales use the same 7-point ordinal scale. Respondents should mark only one answer for each item. Items should be coded as indicated in Table 1.

Table 1
Coding for Subjective Scales

Subjective Scales	Items	Coding for Subjective Items
General Life Satisfaction	1, 17	1 = Terrible
Satisfaction with Living Situation	2a, 2b, 2c	2 = Unhappy
Satisfaction with Leisure Activities	3b, 3c, 3d	3 = Mostly Dissatisfied
Satisfaction with Daily Activities	3a	4 = Mixed
Satisfaction with Family Relationships	6a, 6b	5 = Mostly Satisfied
Satisfaction with Social Relations	8a, 8b, 8c, 8d	6 = Pleased
Satisfaction with Finances	11a, 11b, 11c	7 = Delighted
Satisfaction with Safety	14a, 14b, 14c	
Satisfaction with Health	16a, 16b, 16c	

In order to obtain the scale score, simply compute the average of all of the items listed next to each scale. For example, for the scale "Satisfaction with Living Situation," assume that a consumer marks a score of **4** on Item 2a, a score of **5** on Item 2b, and a score of **6** on Item 2c. The average of these three scores would be the sum of 4 + 5 + 6 (which is 15) divided by 3 for an average (mean) score of 5. "Daily Activities" is the only area in which an average cannot be computed since it consists of only one item.

Objective Scales

As mentioned previously, certain objective categorical information necessary to measure CMHPC outcome domains is already being gathered by the CSI data system and was not included in the *CA-QOL*. These two areas are: Type of Living Situation and Types of Productive Activities (e.g., work, education, volunteering). The *CA-QOL* does gather subjective information about these domains. The items measuring the remaining seven objective scales come in a variety of formats and should be coded as described in Table 2. As noted previously, these items can be scored individually or combined into scale scores where appropriate (for scales with more than one item).

Note that item number 13 (number of arrests) and item number 15 (health status) are coded so that higher values are a negative outcome. On all other items, higher values indicate a positive outcome.

Table 2
Coding for Objective Scales

Objective Scales	Items	Coding for Objective Items	Scale Scores
Frequency of Family Contacts	4, 5	0 = no family 1 = not at all 2 = less than once a month 3 = at least once a month 4 = at least once a week 5 = at least once a day	Compute mean (excluding those responding 0)
Frequency of Social Contacts	7a, 7b, 7c, 7d	1 = not at all 2 = less than once a month 3 = at least once a month 4 = at least once a week 5 = at least once a day	Compute mean
Amount of Spending Money	9	1 = less than $25 2 = $25 to $50 3 = $51 to $75 4 = $76 to $100 5 = more than $100	Single score
Adequacy of Finances	10a, 10b, 10c, 10d 10e	0 = No 1 = Yes	Compute percent yes/no
Victim of Crime	12a, 12b	0 = No 1 = Yes	Compute percent yes/no
Arrested	13	0 = 0 arrests 1 = 1 arrests 2 = 2 arrests 3 = 3 arrests 4 = 4 arrests 5 = 5 arrests 6 = 6 arrests	Single score Note: for this item high scores are a negative outcome.
General Health Status	15	1 = excellent 2 = very good 3 = good 4 = fair 5 = poor	Single score

California Quality of Life (CA-QOL)*

Client ID Number

0 1 2 3 4 5 6 7 8 9 A B C D E F G H I J K L M N O P Q R S T U V W X Y Z

Link Date (mm-dd-yyyy)

0 1 2 3 4 5 6 7 8 9

County

0 1 2 3 4 5 6 7 8 9

Instructions: **Below is a set of questions about your life. Please answer each question by filling in the bubble that best describes your experience or how you feel. Please fill in only one bubble for each question.**

General Life Satisfaction

	Terrible	Unhappy	Mostly Dissatisfied	Mixed	Mostly Satisfied	Pleased	Delighted
1. How do you feel about your life in general?	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7

Living Situation

2.Think about your current living situation. How do you feel about:

	Terrible	Unhappy	Mostly Dissatisfied	Mixed	Mostly Satisfied	Pleased	Delighted
A. The living arrangements where you live?	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7
B. The privacy you have there?	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7
C. The prospect of staying on where you currently live for a long period of time?	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7

Daily Activities & Functioning

3.Think about how you spend your spare time. How do you feel about:

	Terrible	Unhappy	Mostly Dissatisfied	Mixed	Mostly Satisfied	Pleased	Delighted
A. The way you spend your spare time?	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7
B. The chance you have to enjoy pleasant or beautiful things?	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7
C. The amount of fun you have?	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7
D. The amount of relaxation in your life?	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7

Client ID Number (Must be entered on each page and is used to link pages)

*Adapted from the Full and Brief versions of the Lehman Quality of Life Interview.

20652

Family

4. In general, how often do you talk to a member of your family on the telephone?

- ○ at least once a day
- ○ at least once a week
- ○ at least once a month
- ○ less than once a month
- ○ not at all
- ○ no family

5. In general, how often do you get together with a member of your family?

- ○ at least once a day
- ○ at least once a week
- ○ at least once a month
- ○ less than once a month
- ○ not at all
- ○ no family

6. How do you feel about:

	Terrible	Unhappy	Mostly Dissatisfied	Mixed	Mostly Satisfied	Pleased	Delighted
A. The way you and your family act toward each other?	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7
B. The way things are in general between you and your family?	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7

Social Relations

7. About how often do you do the following?

A. Visit with someone who does not live with you?

- ○ at least once a day
- ○ at least once a week
- ○ at least once a month
- ○ less than once a month
- ○ not at all

B. Telephone someone who does not live with you?

- ○ at least once a day
- ○ at least once a week
- ○ at least once a month
- ○ less than once a month
- ○ not at all

C. Do something with another person that you planned ahead of time?

- ○ at least once a day
- ○ at least once a week
- ○ at least once a month
- ○ less than once a month
- ○ not at all

D. Spend time with someone you consider more than a friend, like a spouse, a boyfriend or a girlfriend?

- ○ at least once a day
- ○ at least once a week
- ○ at least once a month
- ○ less than once a month
- ○ not at all

8. How do you feel about:

	Terrible	Unhappy	Mostly Dissatisfied	Mixed	Mostly Satisfied	Pleased	Delighted
A. The things you do with other people?	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7
B. The amount of time you spend with other people?	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7
C. The people you see socially?	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7
D. The amount of friendship in your life?	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7

Client ID Number (Must be entered on each page and is used to link pages)

20652

Finances

9. On average, how much money did you have to spend on yourself in the past month, not counting money for room and meals?

○ less than $25 ○ $25 to $50 ○ $51 to $75 ○ $76 to $100 ○ more than $100

10. During the past month, did you generally have enough money to cover the following items?

	No	Yes
A. Food?	○	○
B. Clothing?	○	○
C. Housing?	○	○
D. Traveling around for things like shopping, medical appointments, or visiting friends and relatives?	○	○
E. Social activities like movies or eating in restaurants?	○	○

11. In general, how do you feel about:

	Terrible	Unhappy	Mostly Dissatisfied	Mixed	Mostly Satisfied	Pleased	Delighted
A. The amount of money you get?	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7
B. How comfortable and well-off you are financially?	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7
C. The amount of money you have available to spend for fun?	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7

Legal & Safety

12. In the past month, were you a victim of:

	No	Yes
A. Any violent crimes such as assault, rape, mugging, or robbery?	○	○
B. Any nonviolent crimes such as burglary, theft of your property or money or being cheated?	○	○

13. In the past month, have you been arrested or picked-up for any crimes?

○ *0 arrests* ○ *1 arrest* ○ *2 arrests* ○ *3 arrests* ○ *4 arrests* ○ *5 arrests* ○ *6 or more arrests*

14. How do you feel about:

	Terrible	Unhappy	Mostly Dissatisfied	Mixed	Mostly Satisfied	Pleased	Delighted
A. How safe you are on the streets in your neighborhood?	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7
B. How safe you are where you live?	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7
C. The protection you have against being robbed or attacked?	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7

Client ID Number (Must be entered on each page and is used to link pages)

20652

Health

15. In general, would you say your health is:

○ excellent ○ very good ○ good ○ fair ○ poor

16. How do you feel about:

	Terrible	Unhappy	Mostly Dissatisfied	Mixed	Mostly Satisfied	Pleased	Delighted
A. Your health in general?	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7
B. Your physical condition?	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7
C. Your emotional well-being?	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7

Global Rating

	Terrible	Unhappy	Mostly Dissatisfied	Mixed	Mostly Satisfied	Pleased	Delighted
17. How do you feel about your life in general?	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7

18. How did you become involved with this program?

○ **I decided to come in on my own.**

○ **Someone else recommended that I come in.**

○ **I came in against my will.**

The California Quality of Life Survey (CA-QOL) is adapted from Dr. Anthony Lehman's Quality of Life Interview (Full and Brief versions) by a committee representing the State Department of Mental Health, California Mental Health Directors Association, and the California Mental Health Planning Council with the written permission of Dr. Lehman. Questions about the CA-QOL should be directed to the California Department of Mental Health, 1600 9th Street, Sacramento, CA, 95814. For more information about the Lehman Quality of Life Interview, contact: Anthony Lehman, M.D., Department of Psychiatry, University of Maryland Medical Center, 645 West Redwood Street, Baltimore, MD 21201.

Client ID Number (Must be entered on each page and is used to link pages)

20652

Chapter 6
Mental Health Statistics Improvement Program (MHSIP) Consumer Survey

General Information

The Mental Health Statistics Improvement Program (MHSIP) Consumer Survey is a public domain instrument that was developed through a collaborative effort of consumers, the Mental Health Statistics Improvement Program community, and the Center for Mental Health Services. The MHSIP Consumer Survey measures the client's general satisfaction with program services, access to services, appropriateness of treatment, and outcomes of care. The form is designed to be completed by the client in approximately 10 minutes. For the purposes of the Supportive Housing Initiative, a few questions were re-worded to be more general, making the instrument less focused on mental health and more general in its questioning.

Development

The original 40-item MHSIP Consumer Survey was piloted by five states. Based on guidance from the NCQA Behavioral Measurement Advisory Panel, a shorter 21-item version of the instrument was developed. The reduced item set was obtained by using an algorithm that selected items on the basis of their unique contribution to a domain in combination with logical and exploratory factor analytic procedures. DMH added 4 questions to the 21-item form. These included changes in wording to make it more applicable to the California setting and the addition of certain items important to consumers, resulting in a 26-item version.

Psychometrics

The MHSIP Task Force has reported that the 21-item version has psychometric features similar to the original 40-item version. In the five-state study, the reliability coefficients for the domain scales ranged from .65 to .87. The 26-item version is expected to have similar psychometric properties. See Appendix B for a review of psychometric properties.

Scoring

Respondents rate their level of agreement or disagreement with each of the first 26 statements on a scale with values ranging from strongly agree to strongly disagree, and not applicable. The average percentage score for each domain is calculated (domains are access, appropriateness, outcomes and satisfaction with services) and these scores are used to compare programs on these measures. Table

7-1 shows the items that are scored for each domain. As noted earlier, several items were reworded slightly to accommodate those projects and clients that are not mental health programs. For example, question number 17 originally said "Staff and I worked together to plan my treatment." It was revised to say "Staff and I worked together to plan my treatment and/or services."

TABLE 6.1 MHSIP CONSUMER SURVEY DOMAINS

DOMAINS	ITEM NUMBERS
Access	4, 5, 6, 7, 8, 19
Appropriateness	9, 10, 11, 12, 13, 14, 15, 16, 17, 18
Outcomes	20, 21, 22, 23, 24, 25, 26
Satisfaction	1, 2, 3

Clinical Utility

The MHSIP Consumer Survey is not a clinical instrument. It can provide valuable information about client's views on program services.

Administration Procedures

The MHSIP Consumer Survey will be completed after six months in the program, and every six months thereafter, as long as the client is receiving services in the program. It is also collected at discharge. If a client discharges before spending six months in the program, the MHSIP must be completed.

Before giving the form to the client, the project evaluator will write the client identification number, and the project code in the appropriate fields. Make sure the client ID is entered at the bottom left of each page of the form. The method for completing these items is described in Chapter 4, under "Administration Procedures." Also, an envelope should be addressed to Candace Cross-Drew, State of California, Department of Mental Health, Research & Evaluation, 1600 9th Street, Sacramento, CA 95814. The envelop should include postage so that the client will not have to pay for mailing the survey to DMH.

Staff will give the survey and envelope to the client. The client will be informed that responses on the MHSIP Consumer Survey are completely confidential and the state evaluator at DMH will not release any individual data to the project. Staff will explain that all MHSIP Consumer Survey responses from the project will be aggregated and reported back to the project and service providers in summary

form. To encourage accurate responses, it is crucial that respondents to the MHSIP Consumer Survey be assured of the confidentiality of their responses.

The client will be told that when she/he has completed the form, she/he should put the survey into the envelope and mail it.

Discharged Client Unavailable

There will be times when a client is discharged because she/he has left the program without advance warning and is unavailable to complete the MHSIP Consumer Survey. Some of these clients will simply disappear; others will be incarcerated or hospitalized. Every attempt should be made to get all the forms completed. However, if the client is unavailable, the MHSIP Consumer Survey will not be collected.

Faxing Forms to DMH

The MHSIP Consumer Survey is the only form that will **not** be faxed to DMH. It should be mailed. The client will put the form in a preaddressed and stamped envelope and mail it.

Overlap with Performance Outcome Project

The MHSIP Consumer Report is being used by the Adult Performance Outcome project so it is possible that a client recently will have completed a MHSIP Consumer Report rating her/his mental health services. Since the Supportive Housing Project is separate from mental health services, the client will be asked to complete another MHSIP Consumer Report for the Supportive Housing Project.

Obtaining Forms

The State DMH will provide a clean copy of the MHSIP Consumer Survey to the project evaluator. The project Evaluator will make clear copies to distribute to staff.

MHSIP Consumer Survey

This survey was developed through a collaborative effort of consumers, the Mental Health Statistics Improvement Program (MHSIP) community, and the Center for Mental Health Services.

INSTRUCTIONS: This survey will help us to improve our mental health services for you. Your answers will be kept confidential and will only be used to evaluate and improve the services here. Please indicate your agreement or disagreement with each of the statements below. Fill in the circle that best represents your opinion.

Client ID Number

0 1 2 3 4 5 6 7 8 9 A B C D E F G H I J K L M N O P Q R S T U V W X Y Z

County

0 1 2 3 4 5 6 7 8 9

Link Date (mm-dd-yyyy)

0 1 2 3 4 5 6 7 8 9

		Strongly Agree 5	Agree 4	I am Neutral 3	Disagree 2	Strongly Disagree 1	Not Applicable 0
1.	I like the services that I received here.	○	○	○	○	○	○
2.	If I had other choices, I would still choose to get services from this agency.	○	○	○	○	○	○
3.	I would recommend this agency to a friend or family member.	○	○	○	○	○	○
4.	The location of services was convenient *(parking, public transportation, distance, etc.)*	○	○	○	○	○	○
5.	Staff were willing to help as often as I felt it was necessary.	○	○	○	○	○	○
6.	Staff returned my calls within 24 hours.	○	○	○	○	○	○
7.	Services were available at times that were good for me.	○	○	○	○	○	○
8.	I was able to get all the services I thought I needed.	○	○	○	○	○	○
9.	Staff here believed that I could grow, change, and recover.	○	○	○	○	○	○
10.	I felt safe to raise questions or complain.	○	○	○	○	○	○
11.	Staff told me what side effects to watch for.	○	○	○	○	○	○
12.	Staff respected my wishes about who is, and is not, to be given information about my treatment.	○	○	○	○	○	○

Please Continue on Page 2

Client ID Number (Must be entered on each page and is used to link pages)

20830

	Strongly Agree 5	Agree 4	I am Neutral 3	Disagree 2	Strongly Disagree 1	Not Applicable 0
13. Staff were sensitive to my cultural/ethnic background.	○	○	○	○	○	○
14. Staff helped me so that I could manage my life and recover.	○	○	○	○	○	○
15. I felt that I was treated with respect by the receptionist.	○	○	○	○	○	○
16. I felt comfortable asking questions about my treatment and medication.	○	○	○	○	○	○
17. Staff and I worked together to plan my treatment.	○	○	○	○	○	○
18. I, not staff, decided my treatment goals.	○	○	○	○	○	○
19. I was given written information that I could understand.	○	○	○	○	○	○

As a Direct Result of Services I Received:

20. I deal more effectively with daily problems.	○	○	○	○	○	○
21. I am better able to control my life.	○	○	○	○	○	○
22. I am better able to deal with crisis.	○	○	○	○	○	○
23. I am getting along better with my family.	○	○	○	○	○	○
24. I do better in social situations.	○	○	○	○	○	○
25. I do better in school and/or work.	○	○	○	○	○	○
26. My symptoms are not bothering me as much.	○	○	○	○	○	○

27. How did you become involved with this program?

○ I decided to come in on my own.
○ Someone else recommended I come in.
○ I came in against my will.

28. What would you like to see changed about this program? (Write comments in box below)

29. Do you currently attend self-help?

○ Yes ○ Not Available ○ No

30. If YES, how often do you participate?

○ Daily ○ Weekly ○ Monthly ○ Occasionally

Client ID Number (Must be entered on each page and is used to link pages)

20830

Chapter 7
Summary of Project Evaluator's Responsibilities

General Information
The project evaluator is the keystone of a successful evaluation of the Supportive Housing Initiative Project. This person has critical data collection and evaluation responsibilities, most of which have been described in previous chapters. This chapter provides a summary of each of the tasks that are the responsibility of the project evaluator.

Responsible for Project Data Collection
The project evaluator is the person designated by the project as the person responsible for the project's Supportive Housing evaluation efforts. As the "Point Person" for the project's evaluation efforts, the project evaluator is the person who will be contacted when there are problems with the project evaluation and who will be expected to resolve the issues.

Making Copies of The Manual
In preparation for training project staff on the administration of the instruments, the project evaluator will make copies of the Evaluator's Training Manual and the CA-QOL scoring manual.

Training Project Staff
Training project and clinical staff on the administration of the forms and the evaluation procedures is the next tasks for the project evaluator. Training the staff will, hopefully, help them understand the importance of their role in the data collection and will ensure accurate data. After training staff, the project Evaluator will send a letter to the State Evaluator that lists the persons trained to complete the forms.

Developing Client Tracking System
The project evaluator will need to develop a tracking system in order to identify when clients enter the program, and when they are due for an annual assessment or a discharge assessment. Since the evaluator is responsible for distributing the correct set of forms, the evaluator will need to have a system to track clients who are approaching their annual assessment or who are about to be discharged.

Tracking Data Collection
Data collection on each project will be overseen by the project evaluator. If there are problems with tardy data collection or forms completed incorrectly, it will be the project evaluator's responsibility to correct these problems. As part of this

tracking of data collection, the project evaluator will make sure that a Consent to Participate (or decline) form is on file for every project participant.

Preparing Forms for Staff

The project evaluator will prepare the appropriate set of evaluation forms for the type of assessment. As discussed in Chapter 2, different assessment periods use a different combinations of forms. Table 8.1 lists the forms that should be completed for each assessment type.

TABLE 7.1 Administration Schedule for Housing Evaluation Forms

ADMISSION	SEMI-ANNUALLY	DISCHARGE - CLIENT AVAILABLE	DISCHARGE - CLIENT UNAVAILABLE
Consent to Participate			
Face sheet	Face sheet	Face Sheet	Face sheet
CA-QOL	CA-QOL	CA-QOL	
	MHSIP Consumer Survey	MHSIP Consumer Survey	

On the Face Sheet, the project evaluator will complete the client ID number, project code, distribution date, assessment type, and form linking number in the appropriate fields. These are described in Chapter 4.

For the CA-QOL and the MHSIP Consumer Survey, the evaluator will complete the client ID, distribution date, project code and form linking number. This is discussed in Chapters 5 and 6.

The project evaluator will also preaddress and stamp the envelopes which are handed out with MHSIP Consumer Survey. This is discussed in Chapter 6.

Distributing Forms to Staff

Once the packet of forms is prepared with the identification fields completed, the project evaluator will distribute the forms to the appropriate staff.

Ensuring Qualified Staff Administer Forms

It is imperative that only staff trained in administering the forms are allowed to do so. If there is staff turnover, the project evaluator will need to train the new staff.

Maintaining File for Consent Forms

Consent (or decline) to participate forms will be maintained in a separate file from clinical records. This file will be maintained by the project evaluator in a locked

cabinet. This file will be made available for inspection by State DMH when requested.

Cost Avoidance Analysis

As required in the legislation for the Supportive Housing Initiative Act (A.B. 2780, Statutes of 1998, Chapter 310), each funded project will be required to collect data to evaluate outcomes related to cost avoidance. This will be submitted to DMH within six months of the end of the project.

Project Specific Outcome Evaluation

Another requirement of the legislation is that the project must also complete an evaluation of project success in achieving each proposed outcome identified by grantees.

Being Important

The project evaluator is the key person in the evaluation efforts. If the data are bad, little can be said about the program's effectiveness and consumer reactions. Good data start with the project evaluator and well trained and committed staff. Filling out the forms is burdensome, but it is a small price to pay for the federal money. Good follow-up data provide support and rationale for additional funds. The critical person in all of this is the project evaluator. The state Department of Mental Health and the consumers thank you for your efforts.

GOOD LUCK!

Appendix A
Project Codes

Fresno	=	1011
Humboldt County	=	1201
Los Angeles (Shields)	=	1901
Los Angeles (Asian Pac.)	=	1902
Los Angeles (The Village)	=	1903
Los Angeles (HFLF)	=	1904
Los Angeles (OPCC)	=	1905
Los Angeles (LAMP)	=	1906
Marin County	=	2101
San Diego County MH	=	3701
San Diego (St. Vincent)	=	3702
San Francisco (The Arc)	=	3801

APPENDIX B- PSYCHOMETRICS

General Information

The term "psychometrics" refers to the practice and technology of applying statistically-based techniques toward the measurement and understanding of psychological "events". These events could include attitudes, personality traits, aptitudes and abilities, and underlying factors relating to psychological functioning. In a clinical setting, which by design is generally centered on a specific individual, some feel that using statistically based assessment tools is not appropriate. Rather, these individuals feel that it is the clinician's professional judgment which grows out of the establishment of a relationship of mutual trust that is most important.

No reasonable psychometrician would claim that statistical data is more important than the relationship that exists between service provider and client. However, psychometric data can, if used appropriately, provide a very valuable piece of the puzzle that helps the clinician to develop a more complete picture of the client. Specifically, **psychometric data provides three essential components to the diagnosis, treatment planning, and service provision process**:

1) Well Defined Areas of Measurement

Scores that are derived from appropriately designed psychometric-based assessment instruments are generally well defined so that something meaningful can be said about a person based on his or her score on that instrument.

2) Reliability

There is evidence that the diagnostic process, when based on clinician judgment alone, is not particularly reliable. In other words, if several clinicians evaluate the same client using the same information, their diagnoses will likely differ to some degree. To the extent that specific diagnoses are more amenable to specific treatment modalities, arriving at an appropriate diagnosis is critical to providing the best service to clients. With psychometric-based data, it is possible to state, in a quantifiable way, how much confidence may be placed in scores that describe the client. This is not to say that those scores are necessarily a complete picture of the client, however. But when psychometric data are used in conjunction with a clinicians clinical judgment, greater confidence may be placed in the overall treatment planning process.

3) Validity

The third and final essential component that psychometric data brings to the diagnosis, treatment planning, and service provision process is a quantifiable level of validity. Because of the intimate and person-centered nature of the clinician-client relationship, a wide variety of factors enter into the judgments made by the clinician about the client. For example, the nature of the clinician's training will guide diagnostic procedures, and will likely lead to a focus on client behaviors that

were emphasized in his or her training; the clinician's own recent and overall professional experience will affect how he or she approaches the client; because the clinician is human, it is likely that his or her own emotional state and personal beliefs will affect judgments made about the client; finally, the administrative environment in which the clinician works will likely place constraints on how the clinician-client relationship develops.

Because of the way that psychometric-based assessment instruments are developed, it is possible--within limits--to be sure that the instrument is mainly measuring what it is supposed to measure. This is referred to as "instrument validity." Stated in other terms, validity refers to the extent to which an instrument is measuring what it is supposed to measure and that the clinician can make appropriate judgments based on the instrument score(s).

Some Basic Concepts in Psychometrics

Reliability

Broadly defined, reliability simply refers to the confidence that you can have in a person's score. In some cases, you want to be able to have confidence that the individual would have the same score over time. This is because you have reason to believe that what is being measured should not change over time. For example, if a person passes a driving test in January it is hoped that the same individual would pass the test one year later. At other times, it may not be appropriate to expect that scores would remain consistent over time. For example, it is hoped that if a client receives treatment for depression, the score that the client would receive on a measure of depression should decrease over time. Psychometricians and other measurement specialists have developed various methods of establishing reliability to meet these varying needs. Some of these are listed below:

Test-Retest Reliability

In test-retest reliability methodologies, an assessment instrument is administered at time 1 and then again at some later date(s). To the extent that the scores that the client receives are the same on both administrations, the two sets of scores will be positively correlated. The correlation coefficient between these two administrations then becomes an estimate of the ability of the assessment instrument to reliably assess the client over time.

Problems with this approach: The main problem with the test-retest approach to establishing validity is that a wide variety of intervening variables can come into play between the first and subsequent administrations of the instrument. An example from the educational setting might be that a college entrance examination is administered to students at the beginning of their Junior year of high school. If the same instrument were administered again at the end of those same students' senior year, the scores would likely be quite different due to all of the intervening

learning that took place. From a psychological standpoint, if a person completed a measure of depression at time one and them experienced some major life event before the second administration of the measure, the estimate of the instrument's reliability would appear low. Finally, it is possible that, having completed the instrument one time the clinician's or client's responses may be affected at the second administration if he or she remembers the previous responses.

If, on the other hand, it is hypothesized that whatever the assessment instrument is measuring really should not change over time, then the test-retest approach is a powerful method of establishing this fact.

Parallel Forms Reliability

Another way of establishing reliability is to develop two forms of the same instrument. In theory, if the two forms are measuring the same thing (e.g., depression), then the scores on the two forms should be highly and significantly correlated. To the extent that they are in fact correlated, the correlation coefficient is roughly a measure of parallel forms reliability.

Problems with this approach: There are several problems with this method of establishing reliability. First, it can be expensive to develop two parallel forms. The second and perhaps greater problem is that there is always a certain amount of "criterion contamination" or variance that is unrelated to what is intended to be measured in an instrument score. This is compounded in that if there is a certain amount of unsystematic variance in each assessment instrument, then the sum of that variance across the two forms will reduce the reliability between the forms.

Split-Half Reliability

This method of establishing reliability is similar to the parallel forms method--but with one important difference. To use the split-half method, an assessment instrument is administered to a group of individuals. Next the instrument is essentially randomly divided into to equal portions. These two portions are then evaluated to examine how strongly they are correlated. Assuming that the instrument is measuring a common trait, ability, or psychological dimension, each half of the randomly divided instrument should be a measure of the same thing. Therefore, scores on each half should be highly correlated.

Problems with this approach: There are two main problems with this approach. First, when you divide the assessment instrument in half, you effectively reduce the number of items from which the total score is calculated by half. Thus, you may by nature have a score on each half that is of lower reliability and therefore any correlation between the two halves could be reduced. Therefore, the overall estimate of reliability could appear inappropriately low. The second problem is that even though the assessment instrument was randomly divided, there is no guarantee

that the two halves are actually equivalent. To the extent that they are not, the estimate of overall reliability will be lower.

Internal Consistency

The internal consistency approach to establishing reliability essentially evaluates the inter-item correlations within the instrument. Ultimately, an estimate of reliability is generated that is equivalent to the average of all possible split-half divisions that could have been made for that instrument.

TABLE 3-1: Summary of Reliability Methodologies

Method	Strengths	Weaknesses
Test-Retest Reliability	• Correlates scores from two separate administrations of an instrument. • Correlation coefficient estimates instrument's ability to reliably assess client over time.	• A wide variety of intervening variables between the first and subsequent administrations of the instrument could alter the results.
Parallel Forms Reliability	• Correlates scores of two forms of an instrument designed to measure the same thing. • Correlation coefficient estimates instrument's ability to measure the target domain.	• It can be expensive to develop two parallel forms. • There is always a certain amount of variance unrelated to what is intended to be measured in an instrument score that would reduce the reliability between the forms.
Split-Half Reliability	• Correlates scores for two equal, randomly divided portions of an instrument. • Correlation coefficient estimates instrument's ability to measure the target domain.	• Since only 50% of the items are used per score, the overall estimate of reliability could appear inappropriately low. • To the extent that the two halves are not equivalent, the estimate of overall reliability will be lower.
Internal Consistency	• Evaluates the inter-item correlations within the instrument. • An estimate of reliability is generated equivalent to the average of all possible split-half divisions.	

Validity

Some people misuse the term "validity" when they refer to assessment instruments. It is inappropriate to say that an assessment instrument is valid. Rather, it is the inferences or decisions that are made on the basis of an instrument's scores that are either valid or

invalid. In order to be able to make valid inferences about a client based on his or her score on an instrument, the instrument must be measuring what it was intended to measure. This point cannot be emphasized enough.

When a client completes an instrument that is designed to evaluate his or her psychological functioning, if the instrument uses terms that, while common in a European cultural setting, may not be familiar in an Asian setting, then the inferences based on the instrument scores may not be appropriate for Asians. Threats to validity do not have to be nearly so extreme or obvious to make interpretation of scores invalid for making assessments. Therefore, it is important for users of test information to understand methods of test validation, the strengths and weaknesses of each, and what types of inferences are more appropriate for the method of validation that was used. Several validation methods are discussed briefly below.

Content Validity

When one says that an instrument is content valid, it indicates that the individual items that make up the instrument are reflective of the specific domain that they are intended to measure. For example, in an instrument designed to measure quality of life, if that instrument contains items such as indicators of living situation, independence, self-sufficiency, etc. (assuming these have been documented by a group of individuals as measuring quality of life), then the instrument may arguably be called "content valid."

Criterion-Related Validity

There are basically two methods of employing criterion-related validation strategies. These are: a) predictive and b) concurrent.

In predictive criterion-related validation strategies, the goal is to develop an instrument that is able to predict a persons later score, performance, or outcome based on some initial score. Examples of such predictive instruments include the General Aptitude Test Battery (GATB), Armed Services Vocational Aptitude Battery (ASVAB), Scholastic Aptitude Test (SAT), and Graduate Record Examination (GRE).

In concurrent criterion-related validation strategies, the goal is to effectively discriminate between individuals of groups on some current trait. For example, the Minnesota Multiphasic Personality Inventory (MMPI) was developed using a method called criterion keying to develop an instrument that was extremely powerful at identifying whether or not a person was currently experiencing psychoses.

The criterion-related validation approach can be extremely powerful. However, it suffers from a variety of conceptual and/or logistical problems. Although I will

not delve deeply into the statistical reasons for these problems, I will list them. Using a criterion-related validation strategy:

- It is difficult to develop parallel forms.
- Instruments tend to have low internal consistency.
- To maximize predictive power, items should have minimal correlations with each other but maximum correlations with the external criterion. This makes it methodologically difficult to identify test items.
- Instruments tend to have low face validity.

Construct Validity

Construct validation approaches utilize factor analysis to identify items that appear to be highly correlated to one another. To the extent that items are, in fact, correlated to each other they are assumed to be measuring something in common. Exactly what those items are measuring is difficult to say. What test developers do is review the content of the items and try to identify commonalties in the subject matter that they cover. For example, if a group of inter-correlated items addresses such things as sleeplessness, lack of energy, frequent crying, fear of being alone, etc., a test developer may decide that these items are measuring the construct of depression.

What is a construct? It is important to keep in mind that a construct does not exist. Rather, it is a theoretical creation to explain something that is observed. Returning to our example of a depression construct, depression is not a thing that exists. Rather, it is simply a name that we have given to a group of traits or a level of psychological functioning.

Face Validity

Face validity simply refers to the extent to which an assessment instrument "appears" to be related to what it purports to measure. For example, a driving test is face valid because all of the questions that are asked are related to laws and situations that a driver may be faced with. Therefore, even if we don't like driving tests, most of use feel that they are at least somewhat related to driving.

On the other hand, someone may find that math ability is related to driving ability. If this occurred, it would be possible to administer a math test and, based on the scores a test taker received, either approve or deny a drivers license. In this case, a math test could be valid for use in predicting driving behavior, but it would not be face valid because it would "appear" unrelated to the task of driving.

Face validity is important in most assessment settings because people inherently like to make sense out of what they are doing. When clinicians, clients, family members, or anyone else are asked to fill out an assessment instrument, they will

feel better about doing so and will likely provide more accurate data if they feel that the information they provide makes sense and can see how it can be useful.

TABLE 3-2: Summary of Validation Methodologies

Method	Strengths	Weaknesses
Content Validity	• Provides an indication of how the individual items that make up the instrument are reflective of the specific domain that they are intended to measure.	• Assumes that the area being measured is clearly understood. • To the extent that what is being measured is conceptual or multi-dimensional, effective content-oriented items may be difficult to develop.
Criterion-Related Validity	• *Predictive strategies* provide an indication of how well the instrument is able to predict a later score, performance, or outcome based on some initial score. • *Concurrent strategies* provide an indication of how the instrument effectively discriminates between individuals or groups on some current trait.	• It is difficult to develop parallel forms using this approach. • Instruments tend to have low internal consistency. • To maximize predictive power, items should have minimal correlations with each other but maximum correlations with the external criterion making it methodologically difficult to identify test items. • Instruments tend to have low face validity.
Construct Validity	• Utilizes factor analysis to identify items that appear to be highly correlated to one another in order to develop assessment instruments that measure a common construct.	• Exactly what a group of inter-correlated items is measuring may be difficult to ascertain.
Face Validity	• Provides an indication of how the assessment instrument "appears" to be related to what it purports to measure	• Not really an indicator of validity. Rather, it is based on the assumption that data will be more valid when respondents see the relationship between the instrument and what it is supposed to measure.

Conclusion

Psychometric data is intended to provide an additional tool for clinicians and other service providers to use as they plan and conduct their treatment. It is not intended to supplant or replace clinical judgment. The above issues have been discussed to help those who use data generated from the Children and Youth Performance Outcome System evaluate and make more effective and appropriate use of their client's assessment data.

It is important to understand which method was used to validate each of the clinical assessment instruments so that you can know what kinds of judgments may be made about the scores. Knowing that an instrument is reliable and how the reliability was established can help the clinician have confidence in the scores as well as know what kinds of changes are reasonable to expect.

Finally, the remainder of this training document goes into additional detail on each of the assessment instruments. Each instrument's validity, reliability, administration and scoring procedures, interpretation, and use will be discussed. The above information is intended to help you make sense of this.

Sources of Further Information

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